Billing and Coding Guidelines:

CHIRO-001 - Chiropractic Services

Revision Efective Date
05/01/2014

AMA CPT/ ADA CDT Copyright Statement

CMS National Coverage Policy
Language quoted from Centers for Medicare and Medicaid Services (CMS). National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:
CMS Pub. 100-02 Chapter 15 §30.5, 40.4, 220.
CMS Pub. 100-02 Chapter 15 §240 - 240.1.5.
CMS Pub. 100-04 Chapter 12 §220
CMS Pub. 100-04 Chapter 23 §20.9.1.1
Title XVIII of the Social Security Act
Section 1833 (e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.
Section 1862 (a) (1) (A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
Part 411.15., subpart A addresses general exclusions and exclusion of particular services.

Coverage Guidelines

AT modifier Effective for services rendered on or after 10/01/2004
For Medicare purposes, the AT modifier shall now be used only when chiropractors bill for active/corrective treatment. CR 3449 requires that every chiropractic claim (those containing HCPCS code 98940, 98941, 98942) with a date of service on or after October 1, 2004, to include the Acute Treatment (AT) modifier if active/corrective treatment is being performed.

The AT modifier must not be placed on the claim when maintenance therapy has been provided. Claims without the AT modifier will be considered as maintenance therapy and denied. Chiropractors who give or receive from beneficiaries an ABN shall follow the instructions in Pub. 100-04, Medicare Claims

Processing Manual, Chapter 23, section 20.9.1.1 and include a GA (or in rare instances a GZ) modifier on the claim.

Manual Manipulation. *--Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, i.e., by use of hands. Additionally, manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself*

No other diagnostic or therapeutic service furnished by a chiropractor or under his or her order is covered. This means that if a chiropractor orders, takes, or interprets an x-ray, or any other diagnostic test, the x-ray or other diagnostic test, can be used for claims processing purposes, but Medicare coverage and payment are not available for those services. (Of course, this prohibition does not affect the coverage of x-rays or other diagnostic tests furnished by other practitioners under the program. For example, an x-ray or any diagnostic test taken for the purpose of determining or demonstrating the existence of a subluxation of the spine, is a diagnostic test covered under the Social Security Act if ordered, taken, and interpreted by a physician who is a doctor of medicine or osteopathy.)

Some chiropractors have been identified as using an "intensive care" concept of treatment. Under this approach, multiple daily visits (as many as four or five in a day) are given in the office or clinic and so-called room or ward fees are charged since the patient is confined to bed usually for the day. The room or ward fees are not covered and reimbursement under Medicare will be limited to not more than one treatment per day unless documentation of the reasonableness and necessity for additional treatment is submitted with the claim.

Coding Guidelines

1. Choose all applicable subluxation ICD-9 code(s), found under Section G, to identify the area(s) of subluxation.

   Explanation:
   One or two manipulations:
   If you are billing code 98940, report the code that describes the subluxation in Item 21 position one. Item 21, Position 2 should be used for the symptom/condition/secondary diagnosis. Any additional symptoms or subluxations should be listed in Item 21 positions 3, 4.

   Per CMS, four or more manipulations:
   Providers who want or need to bill more than four diagnosis codes are required to file the Medicare claim electronically, until the 1500 paper form is modified to accommodate more than four diagnosis codes."

   Even though the claim form will only contain the diagnosis for two regions treated, if CMT for more than two regions is being billed, the clinical records MUST document the reasons for treating the other regions. The precise level of subluxation must be specified on the claim and must be listed as the primary diagnosis. The neuromusculosketal condition necessitating the treatment must be listed as the secondary diagnosis.

2. All claims for chiropractic services must include the following information:
   Date of the initiation of the course of treatment.
   Symptom/condition/Secondary Dx Code(s)
   Subluxation(s)/Primary Dx. ICD-9 Code(s)
   Date of Service

Place of Service
Procedure Code
Failure to report these items will result in claim denial or delay.

Note: Date of last x-ray is no longer required. Any date placed in item 19 is considered date of last x-ray. It is recommended that providers do not place any date in item 19 of the CMS-1500 claim form.

3. At least one of the symptoms or conditions, listed in the Local Medical Policy CHIRO-001, must be reported using the appropriate ICD-9 code(s) from the short-term Treatment, Moderate-Term Treatment, or Long-Term Treatment categories. All associated applicable subluxation codes (739.0-739.5) are reported as the primary diagnosis (es)

4. Limitation of Liability rules apply: The purpose of the Limitation of Liability provision is to protect the beneficiary from liability in denial cases under certain conditions when services rendered are found to be not reasonable and medically unnecessary.

   If the provider uses the AT Modifier and believes a service is likely to be denied by Medicare as not being medically necessary, the beneficiary must sign an Advance Beneficiary Notification (ABN) and the GA modifier must be used.

5. The following information must be recorded by the chiropractor and kept on file. The date of the initial treatment or the date of the exacerbation of the existing condition must be entered in Item 14 of Form CMS-1500 or the electronic equivalent. This serves as affirmation by the chiropractor that all documentation required as listed below and in the regulations is being maintained on file by the chiropractor. Specify the precise spinal location and level of subluxation giving rise to the diagnosis and symptoms.

6. Physician signature for progress notes and reports (hand written, electronic). Initials if signed over a typed or printed name or accompanied by a signature log or attestation statement. See CR 6698 for additional information on signature requirements.

Non-Covered Services:
All services other than manual manipulation of the spine for treatment of subluxation of the spine are excluded when ordered or performed by a doctor of chiropractic. Chiropractors are not required to bill these to Medicare. Chiropractic offices may want to submit charges to Medicare to obtain a denial necessary for submitting to a secondary insurance carrier. The following are examples of (not an all inclusive list) of services that, when performed by a Chiropractor, are excluded from Medicare coverage:

- Laboratory tests
- X-rays
- Office Visits (history and physical)
- Physiotherapy
- Traction
- Supplies
- Injections
- Drugs
- Diagnostic studies including EKGs
- Acupuncture
- Orthopedic devices
- Nutritional supplements and counseling

Medicare does not cover chiropractic treatments to extraspinal regions (CPT 98943), which includes the head, upper and lower extremities, rib cage, and abdomen.

Request for Review
When requesting a review, submit documentation that supports the medical necessity of the denied service.

Revision History
05/01/2014 Annual review done 3/20/2014, reformatted CMS references, removed the sentence under Non covered services "and for which the beneficiary is responsible for payment:" because some services could be denied as provider liable.
07/01/2013 removed the statement regarding rubberstamp because it was incomplete, see CR 8219.
04/01/2013 annual review done on 3/1/2013 and updated number 6. Physician signature for progress notes and reports (hand written, electronic). Initials if signed over a typed or printed name or accompanied by a signature log or attestation statement. See CR 6698 for additional information on signature requirements.
07/16/2012, J-8 two, providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12

08/01/2009, one, merged all current Chiropractor LCDs including L26621 MAC J-5, L8469 WI, L10881 IL, L11054 MI, L11054 MN;

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